

§ 52.110

38 CFR Ch. I (7–1–13 Edition)

(3) Private storage space for each participant sufficient for a change of clothes;

(4) Interior signs to facilitate participants' ability to move about the facility independently and safely;

(5) A clean bed available for acute illness, when indicated;

(6) A shower for resident's need, when indicated;

(7) Adequate and comfortable lighting levels in all areas;

(8) Comfortable and safe temperature levels; and

(9) Comfortable sound levels.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this paragraph under control number 2900–0160)

§ 52.110 Participant assessment.

The program management must conduct initially, semi-annually and as required by a change in the participant's condition a comprehensive, accurate, standardized, reproducible assessment of each participant's functional capacity.

(a) *Intake screening.* An intake screening must be completed to determine the appropriateness of the adult day health care program for each participant.

(b) *Enrollment orders.* The program management must have physician orders for the participant's immediate care and a medical assessment, including a medical history and physical examination, within a time frame appropriate to the participant's condition, not to exceed 72 hours after enrollment, except when an examination was performed within five days before enrollment and the findings were provided and placed in the clinical record on enrollment.

(c) *Comprehensive assessments*—(1) The program management must make a comprehensive assessment of a participant's needs using (on and after January 1, 2002) the Minimum Data Set for Home Care (MSD-HC) Instrument Version 2.0, August 2, 2000.

(2) Frequency. Participant assessments must be completed—

(i) No later than 14 calendar days after the date of enrollment; and

(ii) Promptly after a significant change in the participant's physical, mental, or social condition.

(3) Review of assessments. Program management must review each participant no less than once every six months and as appropriate and revise the participant's assessment to assure the continued accuracy of the assessment.

(4) Use. The results of the assessment are used to develop, review, and revise the participant's individualized comprehensive plan of care, under paragraph (e) of this section.

(d) *Accuracy of assessments*—(1) *Coordination.* (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals.

(ii) Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.

(2) *Certification.* Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(e) *Comprehensive care plans*—(1) The program management must develop an individualized comprehensive care plan for each participant that includes measurable objectives and timetables to meet a participant's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—

(i) The services that are to be provided by the program and by other sources to attain or maintain the participant's highest physical, mental, and psychosocial well-being as required under § 52.120;

(ii) Any services that would otherwise be required under § 52.120 but are not provided due to the participant's exercise of rights under § 52.70, including the right to refuse treatment under § 52.70(b)(4);

(iii) Type and scope of interventions to be provided in order to reach desired, realistic outcomes;

(iv) Roles of participant and family/caregiver; and

(v) Discharge or transition plan, including specific criteria for discharge or transfer.

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(2) A comprehensive care plan must be—

(i) Developed within 21 calendar days from the date of the adult day care enrollment and after completion of the comprehensive assessment;

(ii) Assigned to one team member for the accountability of coordinating the completion of the interdisciplinary plan;

(iii) Prepared by an interdisciplinary team that includes the primary physician, a registered nurse with responsibility for the participant, social worker, recreational therapist and other appropriate staff in disciplines as determined by the participant's needs, the participation of the participant, and the participant's family or the participant's legal representative; and

(iv) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must—

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each participant's written plan of care.

(f) *Discharge summary.* Prior to discharging a participant, the program management must prepare a discharge summary that includes—

(1) A recapitulation of the participant's care;

(2) A summary of the participant's status at the time of the discharge to include items in paragraph (c)(2) of this section; and

(3) A discharge/transition plan related to changes in service needs and changes in functional status that prompted another level of care.

(Authority: 38 U.S.C. 101, 501, 1741-1743)

(The Office of Management and Budget has approved the information collection requirements in this paragraph under control number 2900-0160)

§ 52.120 Quality of care.

Each participant must receive, and the program management must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) *Reporting of sentinel events.* (1) Definition. A *sentinel event* is an adverse event that results in the loss of life or limb or permanent loss of function.

(2) Examples of sentinel events are as follows:

(i) Any participant death, paralysis, coma or other major permanent loss of function associated with a medication error; or

(ii) Any suicide or attempted suicide of a participant, including suicides following elopement (unauthorized departure) from the program; or

(iii) Any elopement of a participant from the program resulting in a death or a major permanent loss of function; or

(iv) Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or

(v) Assault, homicide or other crime resulting in a participant's death or major permanent loss of function; or

(vi) A participant's fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall; or

(vii) A serious injury requiring hospitalization.

(3) The program management must report sentinel events to the director of the VA medical center of jurisdiction within 24 hours of identification. The director of the VA medical center of jurisdiction must report sentinel events to the VA Network Director (10N1-22), Assistant Deputy Under Secretary for Health (10N), and Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114), within 24 hours of identification and/or notification by the State home.

(4) The program management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event in an adult day health care program is to prevent future injuries to residents, visitors, and personnel.

(b) *Activities of daily living.* Based on the comprehensive assessment of a resident, the program management must ensure that—